Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
Phone #: **(608) 266-5432**
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

IMPAIRED PROFESSIONALS PROCEDURE

WORK SUPERVISOR REPORT FORM

Complete this form and submit it to IPP on or before each quarterly due date. You may copy this blank form so you have forms for future reports. It is recommended you keep a copy of each completed form for your files.

Please Print Clearly

Name of Employee: _____
Last First Middle

Place of Employment: _____
Name of Employer

Address of Employment: _____
Street City State Zip Code

Employee's Job Title: _____

Date Report is Due: _____ Dates of Employment: _____
Month / Day / Year Month / Day / Year

Hours of Employment: _____ Full-time? _____ Yes _____ No
Part-time? _____ Yes _____ No

Name and Position of Immediate Supervisor: _____
Last First Middle

1. Describe the employee's job responsibilities in the last 3 months. _____

2. Describe the employee's quality of work in the last 3 months. _____

3. Does this employee have access to controlled substances? _____ Yes _____ No
   Does this employee administer controlled substances? _____ Yes _____ No
   Does this employee dispense controlled substances? _____ Yes _____ No
   Have there been any problems with this? _____ Yes _____ No
   If yes, describe further.

4. Describe attendance problems in the last 3 months. _____
_____
_____
_____

5. Describe employee's relationships with others (patients, clients, coworkers) in the last 3 months. _____
_____
_____
_____

6. Has this employee had a work performance evaluation during the last 3 months? _____ Yes _____ No
If yes, enclose a copy._____
_____
_____

7. To the best of your knowledge, do you believe this employee is remaining abstinent from all mood-altering substances, including alcohol? _____ Yes _____ No
If no, explain further.

8. List others at your facility involved in monitoring this employee.

Name: _____
Last First Middle Title
Name: _____
Last First Middle Title
Name: _____
Last First Middle Title

9. Additional comments, questions or concerns: _____
_____
_____
_____
_____
_____

_____ _____
Signature Date

_____
Print Name

(_____) _____
Phone Number

Return the completed form to "IPP" at the above address. (Attach additional sheets if necessary.)